THE ALLIANCE
OF COMMUNITY SERVICE PROVIDERS

ASSOCIATE MEMBER APPLICATION FORM

NAME OF ORGANIZATION: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP+4**: _____

PHONE: _____ **FAX**: _____ **E-MAIL**: _____

CEO/EXECUTIVE DIRECTOR: _____

PRIMARY CONTACT PERSON: _____
(who will represent your organization at The Alliance meetings and receive ongoing correspondence.)

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP+4:** _____

PHONE: _____ **FAX**: _____ **E-MAIL**: _____

***Please provide The Alliance with company brochures or other associated publications**

NATURE OF BUSINESS/SERVICES:

_____

_____

_____

REFERRING ALLIANCE (Regular) MEMBER(S): _____

_____

***If more than one, please list all**

KINDLY COMPLETE-- Briefly, why are you interested in joining The Alliance:

_____

_____

_____